		FOR OHF USE					

LL1

2000
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2000)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0027086, 0030528

Facility Name: Bethshan Association I & Bethshan Association II

Address: 12927 S. Monitor Avenue (Number) Palos Heights (City) 60463-2434 (Zip Code)

County: Cook

Telephone Number: (708) 371-0800 **Fax #** (708) 371-0833

IDPA ID Number: 363038592001/363038592002

Date of Initial License for Current Owners: 7/16/82-BI / 2/7/86-BII

Type of Ownership:

X	VOLUNTARY,NON-PROFIT		PROPRIETARY		GOVERNMENTAL
X	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code 501(C)(3)			Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Steve Goudzwaard **Telephone Number:** (708) 371-0800

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 7/1/99 to 6/30/00 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) _____ (Date)
(Type or Print Name) Steve Goudzwaard
(Title) Director of Finance

Paid Preparer
(Signed) _____ (Date)
(Print Name and Title)
(Firm Name & Address)
(Telephone) ( ) Fax # ( )

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number Bethshan Association I & Bethshan Association II # 7086, 0030528 Report Period Beginning: 7/1/99 Ending: 6/30/00

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4	45	Intermediate/DD	45	16,425	4
5		Sheltered Care (SC)			5
6	16	ICF/DD 16 or Less	16	5,840	6
7	61	TOTALS	61	22,265	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF					8
9	SNF/PED					9
10	ICF					10
11	ICF/DD	15,751			15,751	11
12	SC					12
13	DD 16 OR LESS	5,248			5,248	13
14	TOTALS	20,999			20,999	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 94.31%

D. How many bed-hold days during this year were paid by Public Aid?
1,306 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
none

F. Does the facility maintain a daily midnight census? yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [X] NO [ ]

I. On what date did you start providing long term care at this location?
Date started 7/16/82 & 2/7/86

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date _____ NO [X]

K. Was the facility certified for Medicare during the reporting year?
YES [ ] NO [X] If YES, enter number of beds certified _____ and days of care provided _____

Medicare Intermediary _____

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 2000 Fiscal Year: 2000

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number Bethshan Association I & Bethshan Associatio # 027086, 003052 Report Period Beginning: 7/1/99 Ending: 6/30/00

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	A. General Services											
1	Dietary	145,963	11,121	13,668	170,752		170,752		170,752			1
2	Food Purchase		165,519		165,519		165,519		165,519			2
3	Housekeeping	76,320	31,655		107,975		107,975		107,975			3
4	Laundry	47,143	3,971		51,114		51,114		51,114			4
5	Heat and Other Utilities			40,631	40,631		40,631		40,631			5
6	Maintenance	47,946	20,809	14,751	83,506		83,506		83,506			6
7	Other (specify):* Scavenger Svcs			5,475	5,475		5,475		5,475			7
8	**TOTAL General Services**	317,372	233,075	74,525	624,972		624,972		624,972			8
	B. Health Care and Programs											
9	Medical Director			7,200	7,200		7,200		7,200			9
10	Nursing and Medical Records	1,276,289	34,158	26,630	1,337,077	(18,338)	1,318,739		1,318,739			10
10a	Therapy	102,249	6,670	12,665	121,584		121,584		121,584			10a
11	Activities	102,599	20,157		122,756		122,756		122,756			11
12	Social Services	11,768		3,764	15,532		15,532		15,532			12
13	Nurse Aide Training					18,820	18,820		18,820			13
14	Program Transportation		14,675		14,675		14,675		14,675			14
15	Other (specify):* Day Programming Svcs-CILA			1,265	1,265		1,265	(1,265)				15
16	**TOTAL Health Care and Programs**	1,492,905	75,660	51,524	1,620,089	482	1,620,571	(1,265)	1,619,306			16
	C. General Administration											
17	Administrative	176,233			176,233		176,233		176,233			17
18	Directors Fees											18
19	Professional Services			12,833	12,833	(318)	12,515		12,515			19
20	Dues, Fees, Subscriptions & Promotions			10,131	10,131	318	10,449		10,449			20
21	Clerical & General Office Expenses	92,344	10,849	13,921	117,114		117,114	(6,100)	111,014			21
22	Employee Benefits & Payroll Taxes			320,347	320,347	16,016	336,363	(868)	335,495			22
23	Inservice Training & Education			9,211	9,211	(7,230)	1,981		1,981			23
24	Travel and Seminar			14,176	14,176	1,142	15,318	(5,596)	9,722			24
25	Other Admin. Staff Transportation			1,135	1,135	(1,117)	18		18			25
26	Insurance-Prop.Liab.Malpractice			28,554	28,554		28,554		28,554			26
27	Other (specify):* Misc		10,569		10,569	(9,293)	1,276	(300)	976			27
28	**TOTAL General Administration**	268,577	21,418	410,308	700,303	(482)	699,821	(12,864)	686,957			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	2,078,854	330,153	536,357	2,945,364		2,945,364	(14,129)	2,931,235			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Bethshan Association I & Bethshan Association II #0027086, 0030 Report Period Beginning: 7/1/99 Ending: 6/30/00

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			164,006	164,006		164,006	(21,584)	142,422			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			14,978	14,978		14,978	(3,522)	11,456			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds			64,680	64,680		64,680		64,680			34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	**TOTAL Ownership**			243,664	243,664		243,664	(25,106)	218,558			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			163,452	163,452		163,452		163,452			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**			163,452	163,452		163,452		163,452			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,078,854	330,153	943,473	3,352,480		3,352,480	(39,235)	3,313,245			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number Bethshan Association I & Bethshan Association II #7086, 0030528 Report Period Beginning: 7/1/99 Ending: 6/30/00

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(3,522)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees	(300)	27		17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(6,100)	21		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule see attached	(29,313)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (39,235)		$	30

OHF USE ONLY								
48		49		50		51		52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (39,235)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS

Bethshan Association I & Bethshan Association II

ID# 0027086, 0030528

Report Period Beginning: 7/1/99

Ending: 6/30/00

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Fundraising Employee Benefits	$ (868)	22	1
2	Conference/Seminar Expense for non-direct care staff	(5,596)	24	2
3	Non-Program Expense	(1,265)	15	3
4	Depreciation on assets purchased with grant money			4
5	99 Grand Caravan	(4,584)	30	5
6	99 Dodge Ram	(5,073)	30	6
7	99 Ford Lift Van E350	(6,489)	30	7
8	Automatic Door	(1,296)	30	8
9	Driveway/Lighting/Gazebo	(4,142)	30	9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
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75				75
76				76
77				77
78				78
79				79
80				80
81				81
82				82
83				83
84				84
85				85
86				86
87				87
88				88
89				89
90	**Total**	(29,313)		90

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Bethshan Association I & Bethshan Association II #127086, 00305 Report Period Beginning: 7/1/99 Ending: 6/30/00

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	0	0	0	0	0	0	0	0	0	0	0	0	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	(1,265)	0	0	0	0	0	0	0	0	0	0	(1,265)	15
16	**TOTAL Health Care and Programs**	(1,265)	0	0	0	0	0	0	0	0	0	0	(1,265)	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	0	0	0	0	0	0	0	0	0	0	0	0	20
21	Clerical & General Office Expenses	(6,100)	0	0	0	0	0	0	0	0	0	0	(6,100)	21
22	Employee Benefits & Payroll Taxes	(868)	0	0	0	0	0	0	0	0	0	0	(868)	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	(5,596)	0	0	0	0	0	0	0	0	0	0	(5,596)	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	(300)	0	0	0	0	0	0	0	0	0	0	(300)	27
28	**TOTAL General Administration**	(12,864)	0	0	0	0	0	0	0	0	0	0	(12,864)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(14,129)	0	0	0	0	0	0	0	0	0	0	(14,129)	29

STATE OF ILLINOIS **Summary B**

Facility Name & ID Number **Bethshan Association I & Bethshan Association II** **#127086, 00305** **Report Period Beginning:** **7/1/99** **Ending:** **6/30/00**

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	(21,584)	0	0	0	0	0	0	0	0	0	0	(21,584)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(3,522)	0	0	0	0	0	0	0	0	0	0	(3,522)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(25,106)	0	0	0	0	0	0	0	0	0	0	(25,106)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(39,235)	0	0	0	0	0	0	0	0	0	0	(39,235)	45

Facility Name & ID Number Bethshan Association I & Bethshan Association II # 027086, 00305 Report Period Beginning: 7/1/99 Ending: 6/30/00

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Bethshan Association	100%	Tibstra House	South Holland	Bethshan Foundation	Palos Heights	Charitable Corp.

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [ ] YES [X] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V			$			$	$	1
2	V								2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$			$	$ *	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Bethshan Association I & Bethshan Associat # 0027086, 0030528 Report Period Beginning: 7/1/99 Ending: 6/30/00

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	None								$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Bethshan Association I & Bethshan Association II #)27086, 00305(Report Period Beginning: 7/1/99 Ending: 6/30/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Bethshan Association
Street Address: 12927 S. Monitor Avenue
City / State / Zip Code: Palos Heights, IL 60463-2434
Phone Number: (708) 371-0800
Fax Number: (708) 371-0833

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	2	Workshop meals	# clients	107	10	$ 71,298	$ 0	61	$ 40,647	1
2	6	Maintenance	# beds	120	10	96,576	91,975	61	49,093	2
3	12	Social Services	# beds	120	10	22,951	22,951	61	11,667	3
4	14	Program Transportation	# beds	120	10	21,843	0	61	11,104	4
5	17	Administration	# beds	75	3	108,979	108,979	60	87,183	5
6	19	Professional Services	# beds	120	10	23,569	0	61	11,981	6
7	20	Dues, Fees & Subscriptions	# beds	120	10	10,933	0	61	5,558	7
8	21	Clerical & General Office	# beds	120	10	200,834	178,952	61	102,091	8
9	22	Workers Comp. Insurance	budgeted salaries	3,668,500	10	20,310	0	2,078,417	11,507	9
10	22	Pension	# beds	120	10	8,748	0	61	4,447	10
11	26	Liability Insurance	# beds	120	10	14,695	0	61	7,470	11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 600,736	$ 402,857		$ 342,748	25

Facility Name & ID Number Bethshan Association I & Bethshan Associati #7086, 0030528 Report Period Beginning: 7/1/99 Ending: 6/30/00

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	Bess Tolsma		x	start-up capital		6/26/81	$ 10,000	$ 10,000	on demand	0.1000	$ 1,000	1
2	various noteholders		x	start-up capital		various	246,200	233,200	on demand	0.0600	13,978	2
3												3
4												4
5												5
	Working Capital											
6	Bethshan Foundation	x		operating capital		6/1/98	100,000	106,586	on demand			6
7												7
8												8
9	TOTAL Facility Related						$ 356,200	$ 349,786			$ 14,978	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 356,200	$ 349,786			$ 14,978	15

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number Bethshan Association I & Bethshan Association II # 27086, 00305 Report Period Beginning: 7/1/99 Ending: 6/30/00

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 1999 report.	$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	2
3. Under or (over) accrual (line 2 minus line 1).	$	3
4. Real Estate Tax accrual used for 2000 report. (Detail and explain your calculation of this accrual on the lines below.)	$	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$	5
6. Subtract a refund of real estate taxes used previously to calculate a payment rate. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For 19 Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**	$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
	1995	8
	1996	9
	1997	10
	1998	11
	1999	12

FOR OHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 1999	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

Facility Name & ID Number Bethshan Association I & Bethshan Association II #)27086, 00305 Report Period Beginning: 7/1/99 Ending: 6/30/00

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 24602 & 8693 B. General Construction Type: Exterior brick Frame metal Number of Stories 1

C. Does the Operating Entity? [BI] (a) Own the Facility [ ] (b) Rent from a Related Organization. [BII] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1				$	1
2					2
3	TOTALS			$	3

Facility Name & ID Number Bethshan Association I & Bethshan Association II # 7086, 003052 Report Period Beginning: 7/1/99 Ending: 6/30/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	45		1982	1982	$ 1,116,585	$ 39,090	20-40	$ 39,090	$	$ 700,031	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	remodeling & improvements				147,378	7,131	20-40	7,131		56,679	9
10	fixed equipment				46,021	2,408	10-40	2,408		14,758	10
11	addition - P.T., Nursing, office & Maintenance			1993	385,632	9,641	40	9,641		67,486	11
12	landscaping				18,201	910	20	910		7,804	12
13	automatic door			1999	12,958	1,296	10	1,296		1,590	13
14	garage				7,000	368	15-20	368		5,266	14
15	site improvements				129,369	7,897	10-20	7,897		44,644	15
16	water & sewer improvementS				22,009	734	30	734		12,745	16
17											17
18	woodfold accordion folding partitiion			2000	2,720	7	10	7		7	18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$ 1,887,873	$ 69,482		$ 69,482	$	$ 911,010	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Bethshan Association I & Bethshan Association II #)27086, 0030528 Report Period Beginning: 7/1/99 Ending: 6/30/00

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
37	Purchased in Prior Years	$ 277,441	$ 42,272	$ 42,272	$	five - ten	$ 154,544	37
38	Current Year Purchases	44,877	3,584	3,584		five - ten	3,584	38
39	Fully Depreciated Assets	246,404				five - ten	246,404	39
40								40
41	TOTALS	$ 568,722	$ 45,856	$ 45,856	$		$ 404,532	41

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
42	client transportation	vans	1991-1999	$ 208,019	$ 41,604	$ 41,604	$	5	$ 130,285	42
43	executive director	car	1999	18,714	3,743	3,743		5	5,414	43
44	maintenance	truck	1998	16,611	3,322	3,322		5	8,017	44
45										45
46	TOTALS			$ 243,344	$ 48,669	$ 48,669	$		$ 143,716	46

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
47	Total Historical Cost	(line 3,col.4 + line 36,col.4 + line 41,col.1 + line 46,col.4)	$	2,699,939	47
48	Current Book Depreciation	(line 36,col.5 + line 41,col.2 + line 46,col.5)	$	164,007	48
49	Straight Line Depreciation	(line 36,col.7 + line 41,col.3 + line 46,col.6)	$	164,007	49 **
50	Adjustments	(line 36,col.8 + line 41,col.4 + line 46,col.7)	$		50
51	Accumulated Depreciation	(line 36,col.9 + line 41,col.6 + line 46,col.9)	$	1,459,258	51

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
52		$	$	$	52
53					53
54					54
55					55
56					56
57	TOTALS	$	$	$	57

G. Construction-in-Progress

	Description	Cost	
58		$	58
59			59
60			60
61		$	61

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: Elim Christian Services

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. [ ] YES [X] NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:	1976	16	7/1/98	$ 64,680	3		3
4	Additions							4
5								5
6								6
7	TOTAL		16		$ 64,680 **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease .

9. Option to Buy: [ ] YES [X] NO Terms: *

10. Effective dates of current rental agreement:
Beginning 7/1/98
Ending 6/30/01

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	6/30/2001	$ 64,680
13.	/2002	$
14.	/2003	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? [ ] YES [X] NO

16. Rental Amount for movable equipment: $ Description:
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number Bethshan Association I & Bethshan Association II #)27086, 0030528 Report Period Beginning: 7/1/99 Ending: 6/30/00

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? [X] YES [ ] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
- IN-HOUSE PROGRAM [X]
- IN OTHER FACILITY [ ]
- COMMUNITY COLLEGE [ ]
- HOURS PER AIDE 40

3. CLINICAL PORTION:
- IN-HOUSE PROGRAM [X]
- IN OTHER FACILITY [ ]
- HOURS PER AIDE 80

B. EXPENSES

ALLOCATION OF COSTS (d)

			1 Facility Drop-outs	2 Facility Completed	3 Contract	4 Total
1	Community College Tuition		$	$	$	$
2	Books and Supplies			482		482
3	Classroom Wages	(a)		5,229		5,229
4	Clinical Wages	(b)		10,458		10,458
5	In-House Trainer Wages	(c)		2,651		2,651
6	Transportation					
7	Contractual Payments					
8	Nurse Aide Competency Tests					
9	TOTALS		$	$ 18,820	$	$ 18,820
10	SUM OF line 9, col. 1 and 2	(e)	$ 18,820			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	19
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	19

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	$		$	$		$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			$		$	$		$	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number Bethshan Association I & Bethshan Association II # 7086, 0030528 **Report Period Beginning:** 7/1/99 **Ending:** 6/30/00

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 6/30/00 **(last day of reporting year)**

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ (627,909)	$ 22,737	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	350,110	513,062	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	10,972	22,703	6
7	Other Prepaid Expenses	750	750	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ (266,077)	$ 559,252	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		244,750	13
14	Buildings, at Historical Cost	1,887,873	3,851,119	14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	812,066	1,388,129	16
17	Accumulated Depreciation (book methods)	(1,459,258)	(2,052,095)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 1,240,681	$ 3,431,903	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 974,604	$ 3,991,155	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 126,215	$ 176,046	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	100,000	106,586	29
30	Accrued Salaries Payable	132,519	194,810	30
31	Accrued Taxes Payable (excluding real estate taxes)	2,747	4,607	31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable	4,601	8,906	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Pension Payable	715	1,146	36
37	Wage Garnishments Payable		64	37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 366,797	$ 492,165	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	233,200	233,200	39
40	Mortgage Payable		648,880	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 233,200	$ 882,080	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 599,997	$ 1,374,245	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 374,607	$ 2,616,910	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 974,604	$ 3,991,155	48

***(See instructions.)**

Facility Name & ID Number Bethshan Association I & Bethshan Association II # 0027086, 0030528 Report Period Beginning: 7/1/99 Ending: 6/30/00

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 629,843	1
2	Restatements (describe):		2
3	**Prior Period Adjustment - Accrued Vacation Pay**	(94,714)	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 535,129	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(184,970)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (184,970)	17
	B. Transfers (Itemize):		
18	**BI Carpeting - transfer from building fund**	24,448	18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$ 24,448	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 374,607	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number Bethshan Association I & Bethshan Association II #7086, 0030528 Report Period Beginning: 7/1/99 Ending: 6/30/00

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 2,843,442	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 2,843,442	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$	23
	D. Non-Operating Revenue		
24	Contributions	84,077	24
25	Interest and Other Investment Income***	3,522	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 87,599	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Gain on Sale of Assets	7,500	28
28a	Campus Rate Income Reallocation	228,969	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 236,469	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 3,167,510	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	624,972	31
32	Health Care	1,620,571	32
33	General Administration	699,821	33
	B. Capital Expense		
34	Ownership	243,664	34
	C. Ancillary Expense		
35	Special Cost Centers		35
36	Provider Participation Fee	163,452	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 3,352,480	40
41	**Income before Income Taxes (line 30 minus line 40)****	(184,970)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (184,970)	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? YES If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

**** **Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number Bethshan Association I & Bethshan Association II #7086, 0030528 Report Period Beginning: 7/1/99 Ending: 6/30/00

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,955	2,159	$ 49,344	$ 22.86	1
2	Assistant Director of Nursing					2
3	Registered Nurses	6,236	7,174	129,145	18.00	3
4	Licensed Practical Nurses	4,092	4,478	72,751	16.25	4
5	Nurse Aides & Orderlies					5
6	Nurse Aide Trainees					6
7	Licensed Therapist	5,604	6,183	102,249	16.54	7
8	Rehab/Therapy Aides					8
9	Activity Director	1,752	1,800	21,357	11.87	9
10	Activity Assistants	4,991	5,737	81,242	14.16	10
11	Social Service Workers	330	336	11,768	35.02	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook	1,824	2,080	40,017	19.24	14
15	Cook Helpers/Assistants	10,677	11,561	105,946	9.16	15
16	Dishwashers					16
17	Maintenance Workers	2,720	2,951	47,946	16.25	17
18	Housekeepers	5,375	6,466	76,320	11.80	18
19	Laundry	5,446	5,875	47,143	8.02	19
20	Administrator	1,402	1,664	87,183	52.39	20
21	Assistant Administrator	3,022	3,572	89,050	24.93	21
22	Other Administrative					22
23	Office Manager	1,416	1,560	45,941	29.45	23
24	Clerical	3,440	3,789	46,403	12.25	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)	11,057	12,765	181,003	14.18	28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)	74,110	81,780	844,049	10.32	30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	145,449	161,930	$ 2,078,857 *	$ 12.84	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	249	$ 13,668	1-3	35
36	Medical Director		7,200	9-3	36
37	Medical Records Consultant	32	545	10-3	37
38	Nurse Consultant				38
39	Pharmacist Consultant		1,500	10-3	39
40	Physical Therapy Consultant	201	9,049	10a-3	40
41	Occupational Therapy Consultant	80	3,616	10a-3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	34	1,364	12-3	43
44	Activity Consultant				44
45	Social Service Consultant	104	2,400	12-3	45
46	Other(specify) Poditrist		2,880	10-3	46
47	Psychiatrist	35	6,307	10-3	47
48	Psychologist	89	8,498	10-3	48
49	TOTAL (lines 35 - 48)	824	$ 57,027		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses	80	6,900	10-3	51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)	80	$ 6,900		53

Facility Name & ID Number Bethshan Association I & Bethshan Association II # 7086, 0030528 Report Period Beginning: 7/1/99 Ending: 6/30/00

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Joseph Lanenga	Executive Director	0	$ 87,183
Laura Kirchhoff	Administrator-BI	0	55,563
Frea Mars	Administrator-BII	0	33,487
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 176,233

B. Administrative - Other

Description	Amount
	$
TOTAL (agree to Schedule V, line 17, col. 3)	$
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Ceridian/Paychex	payroll	$ 5,463
Dreyer, Ooms, Van Drunen	audit & accounting	6,467
Hoogendoorn, Talbot, Davids	legal services	185
Coordinated Admin Services	accounting	50
Informability	computer consulting	350
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 12,515

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 11,466
Unemployment Compensation Insurance	9,521
FICA Taxes	150,753
Employee Health Insurance	106,944
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Pension (defined contribution plan)	40,795
Tuition Reimbursement	5,606
Employee Physicals	1,117
Misc. (flowers, gifts, Christmas Party, etc.)	9,293
TOTAL (agree to Schedule V, line 22, col.8)	$ 335,495

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
Personal use of auto	30	$ 6,854
TOTAL		$ 6,854

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	3,088
Health Care Worker Background Check	
(Indicate # of checks performed 45)	520
ARC Membership	2,796
employee prof. licenses/CRPG DDNA dues	579
CSI Ins. Plan	216
CARF	2,338
Subscriptions/VISA/State Filing Fees	416
AOTA/IOTA/AAMR	496
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 10,449

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$ 734
In-State Travel	907
Seminar Expense	8,081
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 9,722

**See instructions.

Facility Name & ID Number Bethshan Association I & Bethshan Association II # 0027086, 0030528 Report Period Beginning: 7/1/99 Ending: 6/30/00

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1997	FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **no**

(2) Are there any dues to nursing home associations included on the cost report? **no**
If YES, give association name and amount.

(3) Did the nursing home make political contributions or payments to a political action organization? **no** If YES, have these costs been properly adjusted out of the cost report?

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **no** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **yes**
What was the average life used for new equipment added during this period? **5**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **n/a** Line

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **no**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **163,452**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **yes** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **no** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **3,192** Has any meal income been offset against related costs? **n/a** Indicate the amount. $

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **no**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **no** If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **100%**
d. Have vehicle usage logs been maintained? **no**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **yes**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **yes**
g. Does the facility transport residents to and from day training? no
Indicate the amount of income earned from providing such transportation during this reporting period. $

(17) Has an audit been performed by an independent certified public accounting firm? **yes**
Firm Name: **Dreyer, Ooms & Van Drunen, Ltd.** The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? **yes** If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **n/a**
Attach invoices and a summary of services for all architect and appraisal fees.